HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Chartered Society of Physiotherapy

The Chartered Society of Physiotherapy welcomes the current inquiry into the future of primary care in Scotland. Physiotherapy has a vital role to play in the delivery and improvement of primary care provision. Physiotherapists work in multi-disciplinary teams in primary care settings.

Demand for primary care is increasing, reflecting an ageing population with often multiple long-term conditions. In order to reduce periods of hospitalisation, increase independence and quality of life and reduce reliance on social care, it is crucial the investment in changes are made to ensure primary care meets its potential to improve Scotland’s health and wellbeing.

Summary
In summary the CSP’s key points are:

- It is important to recognise the full potential of primary care provision beyond GMS services.
- Physiotherapy has the potential to improve primary care, ease pressure points, reduce demand on acute care and social care, support better health outcomes, maintain people’s independence and enhance the quality of life for service users.
- For primary care provision to realise potential, funded expansion of services is required.
- The essential challenge to extending and enhancing services is increasing capacity through increased funding, workforce planning, education and training.

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

The CSP fully supports diversifying the professionals involved in supporting GP clusters to deliver the General Medical Services (GMS) contract. Physiotherapists in First Contact Practitioner roles connected to GPs is an example of how this can transform musculoskeletal (MSK) health care. However, in considering the Committee’s report from the public panels, CSP Scotland would point to a tendency to conflate two different perspectives on what is meant by ‘primary care’. It is unclear from this whether the focus of change is on General Medical Services or takes a wider view of primary care as NHS services in communities that people can directly access.

The CSP believes the wider view is what is required to achieve transformation of primary care, and enhance community services.

There is a great deal of provision of what might be understood to be ‘primary care’ that is not captured by the GMS contract and takes place beyond GP settings. This includes community respiratory teams, care home teams, community rehabilitation services, falls prevention services, for example. Although the Scottish government’s National Clinical Strategy (as referenced in the report) signalled a transformation of ‘primary care’, the CSP and other bodies were critical that the strategy tended to overlook or underestimate NHS provision in community settings that was not GP led. In certain sections, these appeared to be considered as ‘social care’ rather than health care. This wider view of primary care is inclusive of services, often delivered by allied health professions such as physiotherapy, in community settings, that are pivotal in enabling patients to
maintain healthy independent lives in the community, preventing hospital admissions and reducing reliance on social care.

The CSP strongly promotes a ‘whole systems‘ approach to health and wellbeing. Unless all primary care provision is expanded, (not just parts of the system) the transformation of primary care cannot transform health outcomes. Similarly, a whole systems approach to healthy communities also needs to look to third sector and local authority provision outside of primary care.

In supporting the multi-disciplinary approach to the new GP contract, new roles are emerging.

**First Contact Practitioners (FCP)**
The transformation of primary care has seen increasing deployment of physiotherapists to GP settings as ‘first contact practitioners’ in musculoskeletal pathways.

Physiotherapists providing a first point of contact service means that patients presenting with a musculoskeletal (MSK) problem for a GP appointment can be offered an appointment with an advanced (or first contact) practitioner physiotherapist instead. First contact physiotherapists working in general practice have the clinical expertise and autonomy to assess, diagnose and advise patients, carry out further investigations and make onward referral. These new roles are able to address the needs of a large proportion of the patient population.

Data from NHS Forth Valley reveals that using FCPs to take on the GP MSK caseload have enabled standard GP appointment times to increase from ten to fifteen minutes per patient, with 97% of patients reporting confidence in the physiotherapists, and a reduction in onward referrals and drug prescribing. The new GP contract guidance in Scotland highlights the role of first contact practitioners in MSK – but there are opportunities across primary care for respiratory, frail elderly care, and other areas where GP time is devoted to care that can be delivered safely by other health professionals.

**Complex Co-morbidities/Frail Elderly**
Physiotherapists with advance practice skills are also effective in managing complex cases in primary care settings. Where GP’s have patients with complex co-morbidities and multiple long-term conditions, and frequent primary care needs, physiotherapists can reduce reliance on GPs and unnecessary or inappropriate hospital admissions.

- For example, in NHS Lothian, Community Advanced Physiotherapy Practitioners have been employed to manage complex cases in primary care settings. They work alongside a GP with a care home population and patients living at home with complex co-morbidities. The service enhances community case management for complex/frequent primary care attendees, increasing the use of anticipatory care plans and reducing unnecessary hospital admissions.

In addition, there are areas where multidisciplinary community services can enhance health outcomes and reduce demand on acute care, but require significant investment. Examples include:

**Women’s health/pelvic health**
Advanced physiotherapists in pelvic, obstetric and gynaecological physiotherapy often treat patients suffering with incontinence and prolapse before surgery is considered, as for many, specialist physiotherapy care can provide effective treatment and an alternative to surgery.
However, in many areas these services are already stretched to meet current demand. These services have tremendous potential to avoid the need for surgery but are not routinely or equally accessible for communities in Scotland.

**Community rehabilitation** reduces the number of people becoming needlessly disabled and prevented from leading active lives. It also reduces pressures on secondary care. Too often people receive intensive rehabilitation in hospital but then face long waits when they get home, if it’s available at all. For example, pulmonary rehab reduces morbidity and mortality, halves the time patients spend in hospital and reduces readmissions by 26%.\(^1\) Chest Heart Stroke Scotland have highlighted that only nine thousand of sixty-nine thousand people can access pulmonary rehabilitation in Scotland\(^2\). While patients wait their recovery is halted and can reverse – causing lasting disability, distress and deterioration of health.

To maximise independence and reduce disability, a patient’s rehab needs to continue from hospital to home, be easy to re-access and rooted in the community. In managing long term conditions, the role of the third sector and local authority provision must not be underestimated. Intervention by health professionals is often targeted and limited, and ongoing self-management in the community requires complimentary provision, such as rehabilitation groups, walking groups, exercise classes and other ways for people to remain active and feel supported with their conditions. Without this provision, more pressure is placed on primary and acute health services.

**2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?**

**Shifting the balance of care**

The policy to shift the balance of care ‘up-stream’ has proved difficult in that it entails shifting resource to what may appear to be, by definition, ‘non-urgent’ care. Nevertheless, the shift of resources to fund multi-disciplinary teams delivering primary care must be increased if the transformation agenda is to be realised and future demand on the health system is to be better managed. Physiotherapy has the potential to improve primary care, ease pressure points, and reduce demand on secondary care and social care, if the right investment is made. Treating more people in primary care settings must be the health policy objective. Primary care provision in NHS Scotland is under financial pressure, which prevents or limits the expansion of provision.

**Workforce supply**

The supply of physiotherapy graduates needs to be increased to deliver change in primary care, including the planned roll out of MSK First Contact Practitioner roles for GP clusters. The good news is that physiotherapy courses are significantly over subscribed and remains one of the few areas of health where university applications remain buoyant. However, there are insufficient funded places. Current physiotherapy graduate output from Scottish universities is 230 per year, with NHS health boards reporting difficulties in recruiting new graduates. Education and training opportunities to support the full physiotherapy workforce, from support workers through to advanced practice also need to be expanded.

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Physiotherapy workforce planning has made significant strides over the last year. The Scottish government’s draft *Integrated workforce plan for primary care* has featured, for the first time, a section devoted to the increasing the supply of physiotherapists. Figures focussed on the demand for advanced (first contact) practitioners outstripping available supply with 57.5 MSK advanced practitioners in primary care in post, against a demand for 280 such posts in primary care across Scotland in coming years. A planned additional funding for 74 Scottish domiciled training places per year over the next three years is intended to bridge this gap. The CSP is fully behind this increase. However, the CSP remains concerned that a number of challenges have to be addressed if this increased supply can start in January 2020 as planned. The CSP is happy to furnish the committee with further details on the progress of this planned expansion.

**Leadership**
The CSP would highlight the need for whole systems leadership in the design and delivery of primary care. Allied health professions (AHPs) offer an essential perspective on reducing reliance on social care, reducing hospital admissions and maximising independence. However, there is often not the space or opportunity for allied health professional (AHP) leadership to shape decisions. AHP leadership must be a priority area for development for the Scottish government.

**Data collection**
Linked to workforce planning is the need for improved data collection. It is worth noting that the primary care data collected for AHP services is currently poor. To this extent, it is not possible through current data collection to identify the number of physiotherapists or other AHPs working in primary care. Scottish government funded projects to capture AHP activity and workload data and operational service measures, which have the potential to make considerable strides forward. The CSP is concerned that these projects are funded through to fruition. In addition, IT infrastructure requires investment to ensure access by all professionals in all settings.

**Urban and rural healthcare**
Urban and rural communities face different challenges. Services provided to densely populated areas with economies of scale, cannot be a template for rural areas. In diversifying the professionals supporting GP services, for example, the models covering a large remote areas will be different to those where the same multidisciplinary team can support a number of local practices.

**3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?**

As outlined above, improvements in data collection, particularly to data on AHPs in primary care, is essential in supporting evaluation. The CSP would also point to patient reported outcomes, and the quality indicators of the integrated health & social care health and wellbeing outcomes.

In the case of advanced (first contact) practitioners in MSK, the CSP is committed to supporting common data sets to reveal impact data on patient numbers, referrals, self-management and return appointments to the physiotherapist and GP. Data collected so far offers an encouraging picture of the effectiveness of these roles in primary care.

**For further information, contact**
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